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Chairman Dodd, Ranking Member Alexander, Senator Harkin, Members of the Subcommittee, thank you for this opportunity to testify about the number one health threat facing our children today and generations to come—obesity.

I am Dr. Joe Thompson, a father, a pediatrician, the Surgeon General of the State of Arkansas and the Director of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity.

First, I would like to thank all of you for your dedication to this issue. The recently enacted Farm Bill contains some very promising provisions to improve our children's nutrition—specifically the expansion of the Fresh Fruit and Vegetable Program into every state and the Food Stamp Electronic Benefit Transfer demonstration project that will automatically give extra benefits to participants who purchase fruits, vegetables and other healthy foods. All who care about the future of our children and this country are grateful for your leadership on this issue.

However, considering the scope of the childhood obesity epidemic, we must do more.

We did not get here through the malicious actions of industry or government. But, we must intentionally reverse our path, or our families, our communities, our states and the nation will face a future of deteriorating health, lower worker productivity, and an increasing need for social services and health care support.

Many have made investments in this issue. The Robert Wood Johnson Foundation has dedicated $500 million specifically to reverse the epidemic by 2015, and it is working with nonprofits and communities across the nation to support state and local efforts to effect change. States like Arkansas are making substantive changes not only in their programs but also in their strategic planning. Industry also has a role to play, and we are beginning to see both innovative and promising changes come from that arena. Most important, every level of government—including Congress—has a responsibility to contribute to a solution and support communities and states as they strive to prevent and reverse the childhood obesity epidemic.

It is worth repeating the statistics to help frame the discussion:

- Today, almost 32 percent of children and adolescents – more than 23 million – ages 2 to 19 years are obese or overweight.[1]
- Even more startling are the health consequences that follow. Obesity increases the risk for type 2 diabetes, hypertension, osteoarthritis, stroke, certain kinds of cancer and many other debilitating diseases.[2]
- The childhood obesity epidemic cuts across all categories of race, ethnicity, family income and locale, but some populations are at higher risk than others. Low-income individuals, African Americans, Latinos and those living in the southern part of the United States are impacted more than their peers.
- For example, African-American girls are more likely to be obese or overweight than white and Mexican-American girls. Among African-American girls, 39 percent are obese or overweight, compared with 35 percent of Mexican-American girls and 30 percent of white girls.[1]
- Obviously the health consequences are dire, but so are the health care costs to this nation. Childhood obesity alone is estimated to cost $14 billion annually in direct health expenses. Children covered by Medicaid account for $3 billion of those expenses.[3]

How did we get here? There is no single answer. The dramatic increase in obesity that both adults and children in nation have experienced over the past three decades is caused by a confluence of movements, changing influences, daily realities and the economic climate. Consider some of the macro and micro shifts in our culture and daily lives that shape our children's health:

- Many supermarkets have moved out of both rural areas and blighted urban areas, leaving residents without access to healthy, affordable foods. Food deserts are spreading across the nation. Children living in these deserts do not get to eat many fresh fruits and vegetables, but they are certain to know who Ronald McDonald is.
- Similarly, there are recreation deserts, because parks are much less common in low-income and minority neighborhoods. And even when they do exist, lack of safety and perceptions about safety are critical barriers that impact children's ability to play and be active on daily basis.
- Because of urban sprawl, communities are becoming less and less livable. Increasingly designed with cars in mind, our neighborhoods are frequently not walkable or safe places for kids to play. Consequently, fewer than 15 percent of kids walk or bike to school, in part because street designs and traffic make it unpractical and unsafe.

[1] Ogden CL, Carroll MD, Flegal KM. High Body Mass Index for Age Among US Children and Adolescents, 2003-2006. *Journal of the American Medical Association* 2008;299(20):2401-2405.

[2] *Health Consequences*. Centers for Disease Control and Prevention, 2007. Available at www.cdc.gov/nccdphp/dnpa/obesity/consequences.htm Accessed 19 Jul 2008.

[3] *Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions.* Thomson Medstat Research Brief, 2006. Available at www.medstat.com/pdfs/childhood_obesity.pdf. Accessed 19 Jul 2008.

- And when kids get to school, they'll find that requirements in No Child Left Behind to meet annual yearly progress in reading and math have squeezed out time for recess and physical education, despite evidence that active kids perform better academically.[4]
- Despite the 2004 Child Nutrition Reauthorization Act requiring that each school district have a school wellness policy that addresses physical activity and nutrition standards for foods in schools, implementation of these policies is far from universal.
- Furthermore, in many cases, the relationship between schools and vending machines presents a conflict of interest. While many schools have become dependent upon even limited revenue from vending machines to supplement stretched budgets, we should not be surprised when this and the next generation of young adults get a non-nutritious, unhealthy breakfast and lunch from vending machines.
- After school, kids spend too much of their time watching television or playing video games—in fact, 50 percent of all 3-year-olds have a television in their bedrooms.
- Through television, schools and, increasingly, through digital media, the food industry spends millions of dollars each year marketing high-calorie foods and beverages that have poor nutritional value to children and adolescents.
- Most schools lock their gates at the end of the day, preventing students and the broader community from using these public facilities that are in every neighborhood for recreation purposes.
- Community-based youth programs, like Little League, that encourage sports have declined, and they are less available to the low-income children at highest risk for obesity.

All of these changes have created an environment that makes it difficult, inconvenient, expensive, dangerous or even impossible for most families and many children and teens to eat healthy foods and be active. This will not change if we do not act quickly and deliberately at the community, state and federal levels to create healthy environments where we live, learn, work and play.

Today, I want to talk to you about the success we are having in Arkansas in halting this epidemic as a result of comprehensive landmark legislation addressing healthy eating and active living; the type of resources and support state and local communities need to fight this epidemic; and evidence-based recommendations on how Congress can help states and local communities prevent and reverse the childhood obesity epidemic.

Arkansas is similar to many other southern states—at risk for and paying the price for poor health. Compared with the nation as a whole, we have disproportionately high rates of disease and infant mortality, low life expectancy and low economic status. Like other southern states, Arkansas is also disproportionately burdened by obesity risks in both adults and children. Almost one out of every three adults in Arkansas is obese.[5]

[4] Trudeau F, Shephard RJ. Physical education, school physical activity, school sports and academic performance. *International Journal of Behavioral Nutrition and Physical Activity.* 2008;5:10.

[5] Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, GA: U. S. Department of Health and Human Services, CDC; 2007. Available at apps.nccd.cdc.gov/brfss/index.asp. Accessed 12 May 2008.

However, in many ways Arkansas is different because we do not accept the status quo and are doing something about childhood obesity. In 2003 we passed Act 1220, which led to the first and most comprehensive legislatively mandated childhood obesity prevention program in the country. We had three goals;

- change the environment within which children go to school and learn health habits every day;
- engage the community to support parents and build a system that encourages health; and
- enhance awareness of child and adolescent obesity to mobilize resources and establish support structures.

Specifically the law included provisions aimed at:

- improving access to healthier foods in schools, including changing access to and contents of vending machines;
- establishing physical activity requirements;
- creating local parent advisory committees for all schools;
- publicly disclosing so-called pouring contracts; and
- reporting each student's body mass index (BMI) to his or her parents in the form of a confidential health report.

As the Director of the Arkansas Center for Health Improvement, I led the implementation of the BMI assessment program, and I am proud to say that we have halted the epidemic in Arkansas. It took the work of the schools, the community, parents, teachers and kids alike to commit to this system-wide change for the good of their own health and the future of our state and our country. We changed the environment through policies and programs that now support a healthier and more active lifestyle.

When we began measuring our kids' BMIs in school year 2003/2004, nationally a little less than 34 percent of children ages 2 to 19 were either overweight or obese.[6] Based on statewide evaluations of virtually all public school students in Arkansas, more than 38 percent of our children and teens were in the two highest weight categories. However, during the next three years (2005–2007) we found that we had stopped progression of the epidemic – the rate of overweight and obesity remained virtually unchanged at 38 percent per year.[7] While the rate of childhood obesity in Arkansas is still too high, we are encouraged that our efforts have been successful and that the epidemic has been halted in our state. Now, we can turn our efforts to reversing the trend in our state and sharing lessons learned to inform national efforts.

The most recent evaluation by the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences[8] shows that Arkansas's law is working to create a healthier environment in schools across the state. Some of the key findings of the report include the following:

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[6] Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999-2004. *Journal of the American Medical Association* 2006;295(13):1549-55.

[7] Arkansas Center for Health Improvement. *Year Four Assessment of Childhood and Adolescent Obesity in Arkansas (Fall 2006–Spring 2007)*, Little Rock, AR: ACHI, September 2007.

[8] Fay W. Boozman College of Public Health. *Year Four Evaluation: Arkansas Act 1220 of 2003 to Combat Childhood Obesity*. Little Rock, AR: University of Arkansas for Medical Sciences; 2008. Available at www.uams.edu/coph/reports/#Obesity. Accessed Jun 30 2008.

- The BMI assessments have been accepted and found helpful by parents—recognition of obesity risk by parents of overweight children has doubled in the first 3 years.
- Sixty-one percent of school districts in Arkansas have policies requiring nutritious foods be available in vending machines, up from just 18 percent in 2004.
- Twenty-six percent of vending items at schools are in a healthy category, up from 18 percent four years ago. [1]
- Seventy-two percent of students increased their physical activity, up 10 percent from the previous year's study.
- Parents are making efforts to create healthier environments at home by limiting the time their children spend in front of a television or video game screen and by encouraging more physical activity.

Beyond the statistics, the positive impact that our policy changes are having on individual kids like “Samantha” has been the one of most encouraging success stories. Samantha was a 10 years old when a routine screening at her school showed that she was at serious risk for obesity. Her mother, who thought Samantha was going through a harmless phase she’d outgrow, got the message. In addition to embracing changes made at school, Samantha’s family also took steps to improve their health at home: eating better, reducing TV time and becoming more physically active. Samantha’s BMI percentile dropped, and her weight classification changed from the highest category to a healthy weight. She’s kept extra weight off and feels better than ever before.

This is what has worked for Arkansas. In order to help other states model this program and the changes we made in our state, we need to identify and disseminate best practices., I want to ask the U.S. Congress for help in sustaining our state-based effort and expanding it to the nation.

Beyond what is happening in my home state, there is a real opportunity for every level of government to play a role in reversing this epidemic. I will touch on the local and state roles only briefly and then discuss the areas where I believe Congress can make a real difference across multiple programs and agencies.

Clearly state and local leadership is key to transforming communities into healthy, supportive environments. Communities need to be walkable and livable, and that means we need to make transportation investments with pedestrians and cyclists in mind. More sidewalks and bike lanes would make it easier for children to walk to school safely. We also need to maintain parks and play spaces, and make sure these areas are safe so parents will feel comfortable letting their children play outside.

Our cities and urban areas should not be food deserts. We need to attract supermarkets back to these areas through financial incentives so residents don’t have to make a choice between purchasing healthy foods or making their rent and paying for gas.

Schools need to be havens of health, not contributors to the problem. We need to implement school wellness policies, make vending contracts public, improve the content of school breakfasts and lunches, and get high-sugar, high-calorie drinks and junk food out of the vending

machines. States can improve physical activity requirements, provide teacher training and ensure accountability. We need to take a similar track in the community by expanding and promoting opportunities for physical activity through capital improvement programs and planning.

States face challenges, too, and the very real burden of balancing their budgets every fiscal year. Whether it is transportation, education, health care, economic development, or critical capital investments, states work to implement many programs in collaboration and partnership with the federal government and in support of local communities. We need all levels of government to work together and we need some changes.

While changes at the community level are essential, there is also a strong role for the federal government to play in reversing this epidemic, and the upcoming 111th Congress is ripe with opportunity. Not only is health care reform going to be a top priority in both chambers – and we cannot have true health care reform without shifting our focus to prevention– there is a perfect confluence of opportunities through reauthorization of existing programs that can positively influence the trajectory of childhood obesity in this country.

Based on the evidence about what works, the Robert Wood Johnson Foundation has identified five areas for policy change aimed at increasing physical activity and healthy eating among children and adolescents, decreasing sedentary behavior and, ultimately, preventing obesity. They include: providing healthier foods to students at school; improving the availability of healthy foods in all households; increasing the frequency, intensity and duration of physical activity at school; improving access to safe places where children can play; and limiting screen time.

As Congress looks ahead to these reauthorization bills, your goal should be to include specific policy pathways, developed from these evidence-based strategies, in key pieces of legislation.

First, for the reauthorization of the Child Nutrition and Women, Infants, and Children Program, I recommend the following:

- Give the U.S. Department of Agriculture broader authority to require nutrition standards for all foods and beverages sold during the school day and regulate the content and sale of competitive foods, including those sold in vending machines and school stores.
- Increase federal reimbursement rates for school meals to help offset the rising cost of food.
- Help schools meet stronger national nutritional guidelines by providing grants for upgrades to cafeterias and kitchen facilities so healthier food may be cooked and served.

Second, Congress is planning to reauthorize the landmark No Child Left Behind law, which has made important strides in improving academic achievement in this country and has the noble goal of all ensuring all students have access to high-quality education regardless of their socioeconomic status.

I recognize the critical importance of academic achievement, but I also embrace recent studies that have shown the active child is the child more ready to learn and may have greater academic success. At the very least, we know that taking time out for physical education does not negatively impact academic success. You do not have to sacrifice children's health for academic achievement.

As Congress considers this important reauthorization, you should incorporate a physical fitness index or physical education quality score in school performance ratings. Schools do not have to require physical education, but rather could establish a performance indicator that places physical health on the map with academic achievement.

I've never heard a mom say she wanted an educated, unhealthy child OR a healthy, uneducated child—she wants both for her child. We can do this by making achievement goals within No Child Left Behind work together.

Third, Congress has the opportunity to reauthorize the federal surface transportation bill, known as SAFETEA-LU. While this bill is typically thought of as a highway funding bill, Congress should recognize the even larger scope of the bill, which impacts opportunities for regular physical activity. Specifically, Congress should:

- Ensure that children can walk and bicycle safely to school by increasing funding for the Safe Routes to School programs.
- Implement Complete Streets that are designed and operated to enable the safe and convenient travel of all users of the roadway, including pedestrians, bicyclists, users of public transit, motorists, children, the elderly and people with disabilities.
- Provide incentives to use transportation funds linked with land use decisions that create walkable and bikeable communities where people can get where they need go to without having to drive.

Finally, as Congress debates the reauthorization of the children's health bill, you should include obesity as a treatable condition in the State Children's Health Insurance Program (SCHIP) reauthorization and Medicaid rules and regulations, which would establish childhood obesity as a precursor to adult obesity-related conditions that threaten individual life expectancy and the vitality of our workforce. Neither Medicaid nor most private insurance plans provide coverage for obesity-related services. Thus, these benefits may not be part of the plans from which SCHIP coverage is developed. To more effectively address rising childhood obesity rates, obesity needs to be considered not just a risk factor, but a condition that requires medical attention.

In addition to the reauthorization of these major laws, Congress has the opportunity to help shore up program and research funding at the U.S. Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) during the annual appropriations process. Specifically, Congress should fully fund and increase funding for the CDC's Division of Nutrition, Physical Activity and Obesity, which provides grants to states for obesity control and prevention. Currently only half of the states are receiving such funding, putting unfunded states at a substantive disadvantage and their children at dire risk. In addition, I encourage you to charge NIH to prioritize research on how to create more healthful environments that help prevent childhood obesity and support them with fiscal resources to achieve this goal.

The Federal Trade Commission, the Federal Communications Commission and Congress should work together with the food and beverage industry to develop a new set of rules governing the marketing of food and beverages to children. The new rules should apply to all children and adolescents and account for the full spectrum of advertising and marketing practices across all media. If voluntary efforts are unsuccessful in shifting the emphasis away from advertising high-calorie and low-nutrient foods and beverages to advertising of healthful foods and beverages,

Congress should enact legislation mandating the shift on both broadcast and cable TV. Congress could also act to require warnings on all non-nutritious food and beverage advertisements.

This list of recommendations is not exhaustive, but I hope it will serve as a good springboard for Congress to consider to as you make a commitment to preventing childhood obesity. I would also point your attention to the comprehensive recommendations made by the Institute of Medicine in a series of reports it has authored on this critically important issue.[9,10,11,12]

One thing is certain: There has never been a more clear set of opportunities for Congress to make a difference across multiple programs to support states and assist communities across the nation than right now. As I suggested, small changes to these laws and programs can stimulate and reinforce huge changes under way at the state and local levels.

Failure to make these changes will continue to contribute to a toxic environment that unwittingly reinforces poor nutrition and sedentary lifestyles and exacerbates health conditions that threaten the future of our children and our nation.

As a nation, we did not intentionally choose this course, but we must intentionally and immediately work to reverse it.

Speaking for all states, we look forward to working with you, but we need your help and we need it now. Thank you.

[9] Committee on Prevention of Obesity in Children and Youth. *Preventing Childhood Obesity: Health in the Balance*. JP Koplan, CT Liverman, VA Kraak (eds).Washington, DC: The National Academies Press; 2005.

[10] Committee on Progress in Preventing Childhood Obesity. *Progress in Preventing Childhood Obesity: How Do We Measure Up?* Washington, D.C.: National Academies Press; Sept 2006.

[11] Committee on Food Marketing and the Diets of Children and Youth. *Food Marketing to Children and Youth: Threat or Opportunity*. JM McGinnis, JA Gootman, V. Kraak (eds). Washington, D.C.: National Academies Press, 2006.

[12] Committee on Nutrition Standards for Foods in Schools. *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth*. VA Stallings AL Yaktine (eds). Washington, D.C.: National Academies Press, 2007.